STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	297099	A. BUILDING _____ B. WING _____	02/03/2010

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LORIAN HOME SYSTEMS INC OF LAS	3130 SOUTH RAINBOW BLVD SUITE 301 LAS VEGAS, NV 89146

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G 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare recertification survey conducted at your agency on January 27, 2010 through February 3, 2010 in accordance with 42 CFR Part 484 - Home Health Services. The active census at the time of the survey was 86. Fifteen (15) clinical records were reviewed. Five (5) home visits were conducted. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	G 000		
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed to ensure documentation in the patient's record showed effective care coordination for one of 15 patients (Patient #12). Findings include:	G 144	**G 144 484.14 (g)** **COORDINATION OF PATIENT SERVICES** Patient #12: The patient was already discharged at the time the survey results were received. Case conferences are held at least monthly on all active patients. Case Conference Summary Forms will be reviewed after every meeting to ensure effective care coordination is documented. After the survey, all disciplines were informed of the deficiency identified and instructed on the implementation of the requirement. All clinicians were instructed to address the patients' status and progress as well as	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 3/22/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	Continued From page 1 Patient #12 Patient #12's record was reviewed on 2/3/10. The patient was admitted to the agency on 10/7/09, with diagnoses including abnormality of gait, Alzheimer's disease, and lung cancer. For the certification period of December 6, 2009 through February 3, 2010, the physician ordered the services of the Skilled Nurse (SN) for wound care to a newly developed wound, Physical Therapist (PT), and Occupational Therapist (OT), On 1/15/10, the agency held a case conference regarding Patient #12. All the disciplines involved in the patient's care signed the back of the case conference form. The front of the form had preprinted areas for each discipline with preprinted problems. Under SN the problems of "medication teaching/unreliable with meds; disease process teaching; and, wound/healing process/tx (treatment) administration" were checked. There was no documentation on the form for the checked areas to explain what the SN had discussed regarding Patient #12 for those problems. For PT, the problems of "difficulty with transfers; difficulty with gait; poor safety awareness/balance; and, decreased ROM (range of motion)/strength" were checked. There was no documentation on the form for the checked areas to explain what the disciplines had discussed in regards to those problems. For OT, the problems of "difficulty with ADL's (activities of daily living); decreased ROM/strength; and, decreased fine/gross motor skills" were checked. There was no documentation on the form for the checked areas to explain what the disciplines had discussed in regards to those problems. A review of Patient #12's nursing notes indicated	G 144	**G 144 Cont.** document all pertinent information discussed (including, but not limited to, physical status, clinical implications of diagnosis and treatment prescribed, new/changed medications, changes in condition since last case conference, patient progress toward goals and teaching plan and its effectiveness) on the Case Conference Summary Form. A staff meeting and monthly case conference was held on February 15, 2010 to address the purpose and proper documentation of case conferences with emphasis on the importance of establishing effective interchange, adequate reporting and coordination of care. (Attachment 1) Instructions were reiterated during the monthly case conference held on March 15, 2010. (Attachment 2) The DPCS/QA Director conducted a mandatory staff meeting/inservice on March 15, 2010 regarding the importance of care coordination and communication amongst disciplines to ensure delivery of holistic, individualized patient care and adequate documentation of patients' clinical condition and progress. A staff memo dated the same was also sent out to all disciplines addressing these issues. (Attachment 3) New hire employees will be given the same instructions with regard to compliance with this requirement. During case conferences, a QA staff member will record minutes of the meeting to ensure that the discussion of pertinent information is captured and recorded in the Case	

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G 144	Continued From page 2 the wound was slowly healing. A review of the PT notes showed Patient #12 had achieved the goals of therapy and the patient was discharged from PT services on 1/2/10. A review of the OT notes indicated some progress by patient #12 toward therapy goals. This information was not documented on the case conference note. An interview was held with the Administrator on 2/3/10, at 1:45 p.m. The Administrator stated at case conferences each discipline summarized their treatment of the patient and the patient's responds to the treatment, the patient's progress toward the goals of treatment, and any problems or concerns noted by each discipline. The Administrator stated a summary of the discussion should be documented on the case conference form. The agency's undated policy titled "C-360 Coordination of Patient Services" read, "6. Ongoing care conferences shall be conducted to evaluate the patient's status and progress. For each conference, discussion will include, but shall not be limited to, the following: A. Physical status of patient B. Clinical implications of diagnosis and treatment prescribed C. New/changed medications D. Changes in condition since last conference E. New/changed interventions for all disciplines (including changes in frequency/duration of visits F. Justification for continued services G. Progress towards goals H. Teaching plan and its effectiveness." The policy further stated, "Care conferences will be documented on the Care Conference Summary Form."	G 144	**G 144 Cont.** Conference Summary Form. Continued implementation of this requirement will be monitored by the QA Department through routine reviews of case conferences documentation. The DPCS will also monitor compliance by meeting with the QA Director on at least a weekly basis to review compliance. Individuals Responsible: QA Director, DPCS Ultimate Responsibility: DPCS Completion Date: March 15, 2010	
G 158	484.18 ACCEPTANCE OF PATIENTS, POC,	G 158		

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G 158	Continued From page 3 MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the patient's care plan was followed for 1 of 15 patients (Patient #4), and failed to alert the physician of missed visits for 2 of 15 patients (Patient #2, #7). Findings include: Patient #4 Patient #4 was admitted to the agency on 1/2/10 with diagnoses including pressure ulcers, Stage II and III, hypothyroidism, hypertension, congestive heart failure and depression. The resident lived in an assisted living facility. The physician's orders include: - SN (Skilled Nurse) to assess/observe and/or instruct Pt(Patient)/CG (Caregiver): Cardiac Status - Notify Physician of: Systolic > 150 or < 100 Diastolic >90 or <50 Pulse > 100 or < 52 - SN to assess and instruct/observe in Management of disease process to include: HTN (Hypertension), s/s (signs and symptoms) of Infection, Hypotension Episodes, Bradycardia, Wound care. Patient #4's nursing notes dated 1/4/10 indicated	G 158	**G 158 484.18** **ACCEPTANCE OF PATIENTS, POC, MED SUPER** Patient #4: After the survey, the clinician concerned was counseled and reminded that vital signs parameters for notifying the physician as specified by the POC (Plan of Care) must be followed and complied with at all times. If parameters are altered by the physician, such changes to the POC must be documented and subsequently adhered to. Afterwards, the clinician again reported the patient's persistent bradycardia as well as refusal of pacemaker insertion to the physician. The physician then modified the vital signs parameters and changes to the POC were documented and implemented. Subsequent events of bradycardia per parameters were documented and communicated to the physician by said clinician. In addition, the clinician was advised that her initial follow-up on the pacemaker evaluation and the patient's subsequent refusal of the procedure should have been documented. Patient #2: The patient was already discharged at the time the survey results were received. Patient #7: Clinicians assigned to this patient were instructed on timely notification of missed visits to the physician. At the time survey results were received, the patient was ready for discharge from the Agency and no further missed visits occurred. A review of all active patient charts has been completed with a focus on identifying patients with specific vital signs parameters and missed visits to ensure appropriate communication to	

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G 158	Continued From page 4 " Pulse 55 - 48, Bradycardia. Dr. xxx notified re: cardiac concerns . Work up for Pacer (Pacemaker) will be initiated next GP (General Practitioner) visit..." Additional nurse's notes revealed: - 1/05/10 Pulse 30 - 54; "Vascillating dysrhythmia"; - 1/08/10 Pulse 31 - 53; "dropped beat every 3rd beat"; - 1/09/10 Pulse 43 - 48; - 1/21/10 Pulse 44 - 62; "Bradycardia" - 1/22/10 Pulse 90 - 43; S1 - S2 (Sinus 1, Sinus 2) with Mobitz (heart block) to Bradycardia; - 1/27/10 Pulse 32; "Brady (bradycardia) with flux to recovery." There was no documented evidence the physician was notified of Resident #4's episodes of bradycardia for the above dates. In the afternoon of 1/29/10, the skilled nurse (SN) indicated she did not always call the physician when Patient #4 had bradycardia since the physician was aware of the patient's medical problem. The SN indicated the patient required a pacemaker but the patient decided not to have the procedure. There was no documentation in the medical record that the patient had the evaluation for the pacemaker and subsequently refused the procedure. Patient #2 Patient #2 was admitted to the agency on 9/1/09 with diagnoses including Cellulitis of the Leg, Colostomy, Hypertension and DJD (Degenerative	G 158	**G 158 Cont.** the physician was made regarding vital signs falling outside the parameters as well as missed visits. In addition, proper documentation as noted above was reviewed to ensure compliance. A staff meeting was held on February 15, 2010 at which time all clinicians were instructed on notifying physicians of every occurrence of a patient's vital signs falling outside the parameters as specified on the POC. Additionally, staff was instructed that vital signs parameters altered by the physician must be documented and subsequently adhered to at all times. Documentation and communication of missed visits were also addressed with a focus on timely notification of missed visits to the physician. A mandatory staff meeting/inservice was conducted by the DPCS/QA Director on March 15, 2010 to reiterate these instructions. New hire employees will be given the same instructions with regard to compliance with this requirement. A report of pertinent clinical information is communicated by the case manager to the office and clinical staff at start of care and at any event the POC is modified. These reports include, but not limited to, vital signs parameters as well as frequency and duration of ordered disciplines as specified by the POC. The Scheduler will monitor all active patient visit schedules, focusing on ordered frequencies and occurrences of missed visits, at least weekly. Noncompliance by clinicians will be addressed in a timely manner. The QA Department with oversight by the DPCS will	

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G 158	Continued From page 5 Disk Disease) of the Spine. Patient #2's physician's orders included: - 10/24/09 - "Levaquin 250 mg (milligrams)/50 cc (cubic centimeters) D5W (5% Dextrose in Water) via peripheral line QD (every day) x 10 days. Last dose on 11/2/2009..." - 10/31/09 - "IV (Intravenous) antibiotics with Levaquin at same dose to continue up to 11/5/09 as last dose." There was no documented evidence of a SN (skilled nurse) visit on 11/4/09 for the administration of the antibiotic. There was no documented evidence the physician was notified of the missed visit and the missed dose of the IV antibiotic, Levaquin. In the afternoon of 1/29/09, the Acting Director of Nurses confirmed there were no nurse's notes or missed visit report for 11/4/09. Patient #7 Patient # 7 was admitted to the agency on 6/14/09 with diagnoses including DMII (Diabetes Mellitus Type II), Mixed Ulcer of the Calf, Hypertension and Anemia. During the certification period 12/11/09 to 2/8/10, the plan of care included SN (skilled nurse) visits every day for wound care to the right leg ulcer. Documentation in the medical record revealed a missed visit report dated 12/21/09 which indicated the patient/family cancelled the visit due to a family emergency. The section which indicated the physician was notified was left blank.	G 158	**G 158 Cont.** also monitor compliance through concurrent visit/missed visit notes, orders and chart review. Individuals Responsible: Scheduler, QA Director, DPCS Ultimate Responsibility: DPCS Completion Date: March 15, 2010	

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G 158	Continued From page 6 Documentation in the medical record revealed a missed visit report dated 1/25/10 which indicated there was no answer at the door or by telephone. The section which indicated the physician was notified was left blank. On 1/28/10 in the afternoon, the Acting Director of Nurses confirmed there was no documentation in the medical record that the physician was notified of the 2 missed visits.	G 158		
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered according to physician orders for 2 of 15 patients (Patient #2, #6). Findings include: Patient #2 Patient #2 was admitted to the agency on 9/1/09 with diagnoses including Cellulitis of the Leg, Colostomy, Hypertension and DJD (Degenerative Disk Disease) of the Spine. Patient #2's physician's orders included: - 10/24/09 - "Levaquin 250 mg (milligrams)/50 cc (cubic centimeters) D5W (5% Dextrose in Water) via peripheral line QD (every day) x 10 days. Last dose on 11/2/2009..." - 10/31/09 - "IV (Intravenous) antibiotics with Levaquin at same dose to continue up to 11/5/09	G 165	**G 165 484.18** **CONFORMANCE WITH PHYSICIAN ORDERS** Patient #2: Patient was already discharged at the time survey results were received. Patient #6: Immediately after survey, a QA staff member addressed the deficiency identified with the clinician concerned. It was determined that the clinician repeatedly taught the patient on correct insulin administration including dosage, timing and frequency; however, the patient continued to be noncompliant despite adequate instruction, education and reinforcement. The clinician also made numerous attempts to contact the physician for medication clarification; however, the physician had not given further instructions to reconcile and clarify medication orders. The clinician was instructed that all attempts to notify the physician and resolve the issues identified should have been properly documented in the patient's chart. Subsequent visits and communication of all attempts to resolve the issues with the physician or physician's office have been adequately documented. The office staff has since obtained a copy of the patient's list of medications prescribed by the physician's office. Skilled nursing continues to see the patient for medication reconciliation, instruction, education and reinforcement.	

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G 165	Continued From page 7 as last dose." There was no documented evidence of a SN (skilled nurse) visit on 11/4/09 for the administration of the IV antibiotic. In the afternoon of 1/29/09, the Acting Director of Nurses confirmed there was no nurse's notes for the planned visit of 11/4/09. There was no documented evidence the IV antibiotic, Levaquin was administered. Patient #6 Patient #6 was a 73 year old male admitted to the agency on 1/9/10 with diagnoses including DMI (Diabetes Mellitus Type I), Congestive heart Failure, Hypertension, Bilateral Amputation of Legs. Patient #6's plan of care included the following orders: - " Lantus insulin 55 units sq (subcutaneously) qhs (every night)" - " Novolin R (Regular) s/s (sliding scale) per patient > 100 mg(milligram)/dl (deciliter) 8 units sq (subcutaneously) then increase dose by 5 units/100 mg/dl" - "Glucometer testing to be done by patient qid (four times a day)" During the home visit on 1/27/10, the skilled nurse indicated the patient's blood sugar was tested during the SN visit. However, the patient monitored his BS and gave himself the sliding scale insulin. The SN did not know the frequency or dosage of s/s Insulin to be administered. During the home visit on 1/27/10, Patient #6	G 165	**G 165 Cont.** All active patients' medication profiles have been reviewed for accuracy and conformance to physician's orders. All discrepancies will be communicated to and clarified with the physician. A staff meeting was held on February 15, 2010 at which time all clinicians were informed of the deficiencies identified and instructed on the implementation of the required conformance to physicians orders. Importance of proper and accurate completion of medication profiles was reinforced to the clinical staff during a staff meeting held March 15, 2010. All clinicians were reminded that drugs and treatments are administered by agency staff as ordered by the physician. Physicians are to be notified of patient noncompliance (e.g. taking medications other than those prescribed) immediately and the communication documented. In addition, the DPCS/QA Director conducted a mandatory inservice to all the clinicians on March 15, 2010 reinforcing care coordination, compliance with the POC and physicians orders as well as proper documentation. New hire employees will be given the same instructions with regard to compliance with this requirement. The QA Department and DPCS will monitor compliance through oversight of clinician visits and patient care coordination. Field clinicians are to report all concerns regarding patient care including updates to the POC and new physician orders to the QA Department and/or DPCS. The QA Department with oversight by	

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G 165	Continued From page 8 indicated he checked his BS and gave the s/s Novolin insulin coverage as followed: - For a BS > 100 mg/dc he used 5 U Novolin Insulin; - For a BS of 250mg/dc, he would use 7.5 U of Novolin Insulin There was no order which indicated the frequency of administration of the s/s insulin. The s/s insulin dosage as described by the patient, does not correspond to the physician's orders. There was no documented evidence the SN called the physician to clarify the s/s insulin orders.	G 165	**G 165 Cont.** the DPCS will further monitor compliance of accurate documentation by concurrent visit notes and chart review. The DPCS will meet with the QA Director at least weekly to review staff compliance. Individuals Responsible: QA Director, DPCS Ultimate Responsibility: DPCS Completion Date: March 15, 2010	
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on interview and record review, the agency failed for one of 15 sampled patients to review all medications the patient was currently using to identify any potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions and duplicate drug therapy (Patient #12). Findings include: Patient #12 Patient #12's record was reviewed on 2/3/10.	G 337	**G 337 484.55(c)** **DRUG REGIMEN REVIEW** Patient #12: Patient was already discharged at the time survey results were received. The QA Department will conduct an audit of all active patients' medication profiles. Potential side effects not documented on the medication profiles will be addressed with the appropriate clinicians and said medication profiles will be updated and completed to meet compliance. After the survey, clinicians responsible for completing a drug regimen review were informed of the deficiency identified. A staff meeting was held on February 15, 2010 to instruct clinicians that comprehensive assessments must include a review of all medications the patient is currently taking in order to identify any potential adverse effects and drug reactions, including but not limited to, significant side effects. Additionally, the Agency's medication profile and the patient's home medication profile should match and	

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G 337	Continued From page 9 Patient #12 was admitted to the agency on 10/7/09, with diagnosis including abnormality of gait, Alzheimer's disease, and cancer of the lung. A review of the Medication Profile (MP) form for Patient #12 revealed a licensed nurse had recorded the name of the medication, the dose and route of the medication, the frequency of the medication, and the purpose of the medication for the 14 medications currently used by Patient #12. The lines for potential side effects of each of the 14 medications were blank. It was noted that on the back of the MP were numbers which corresponded to drug classifications with the potential side effects printed for each classification. An interview was held with the ADPCS (Acting Director of Patient Care Services) on 2/3/10, at 2:10 p.m. The ADPCS stated when the nurse recorded the medication on the MP, the nurse should look for the number of the classification for that medication and record the classification number on the MP in the column for potential side effects. The agency's undated policy titled "C-700 Medication Profile/Drug Regimen Review" read, "3. The medication profile shall document...G. Medication actions and side effects...J. Drug or food-drug interactions."	G 337	**G 337 Cont.** comply with this requirement, including a review of potential side effects as evidenced by completion of the potential side effects on the spaces provided. Importance of compliance was re-emphasized to the clinical staff during a mandatory meeting/inservice held March 15, 2010. The DPCS will also conduct a clinical inservice meeting on March 31, 2010 on medication management, with focus on drug regimen review, proper completion of medication profiles and high-risk medications. New hire employees will be given the same instructions with regard to compliance with this requirement. The QA Department will routinely track compliance by weekly follow-ups on clinicians identified to have been noncompliant and deficient with required submission and documentation of medication profiles. Clinicians are required to report to the office at least once weekly to complete deficient paperwork. The QA Department will monitor compliance through 100% review of medication profiles submitted and concurrent clinical notes, orders and chart review. The DPCS will also monitor compliance by meeting with the QA Director at least once weekly to review staff compliance. Individuals Responsible: QA Director, DPCS Ultimate Responsibility: DPCS Completion Date: March 31, 2010	